NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 4, 2003

RE: MDR Tracking #: M2-03-0957-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic physician reviewer who is board certified in Orthopedics. The orthopedic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

My board certification is in orthopedic surgery. The service requested, review of decision-making for knee surgery, is within the scope of my practice. This case involves a 56 year-old male millwright/welder who sustained an injury to the right knee while on the job ___, when he twisted the knee as he stepped into a water puddle as he was coming off a ladder. He apparently had some initial pain and swelling but nonetheless continued working and was managed conservatively. With apparent persistence of recurrence of pain, he was seen by the eventual treating orthopedist on 1/30/03, with a history of recurrent pain, swelling, and soreness as well as findings of effusion and some medial tenderness. Subsequent MRI demonstrated a complex tear of the posterior horn of the medial meniscus. The request for arthroscopic intervention was apparently denied by the initial reviewer in the absence of more serious mechanical symptoms. This current review is based upon limited summary notes of clerical reviewers as well as limited office notes from the orthopedist, ___ dated 1/30/03, and 2/17/03.

Requested Service(s)

The current review is to resolve the disputed authorization for arthroscopic partial medial meniscetomy in this case.

Decision

Accordingly, I disagree with the insurance carrier (and the previous physician reviewer), and am of the opinion that the requested surgery is reasonable, medically necessary, and consistent with the injury of ___.

Rationale/Basis for Decision

The records indicate that the injured employee had no previous right knee complaints, injury or treatment before ___, as well as no indication of serious pre-existing arthritic/degenerative changes. The patient seems to have sustained a specific twisting injury consistent with the complaints and MRI findings without any documentation that some other injury or event was a more likely causative factor. While the patient has continued working, the history certainly suggests that he has continued with intermittent symptoms that are becoming more disabling.

The fact that the injured worker has continued working, and has not complained much until more recently, should not be held against him. The previous reviewer seems to have focused on the absence of serious mechanical symptoms such as locking or catching, though clearly many meniscal tears are not of the bucket-handle or loose pedunculated variety that would cause those types of symptoms, and yet nonetheless are associated with persistent pain and swelling that tend to be intermittent dependent upon activities and demands, and may predispose to earlier degenerative changes.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

This decision by the IRO is deemed to be a TWCC decision and order.